SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Filing at a Glance

Company: Industrial Alliance Pacific Insurance and Financial Services Inc.

Product Name: Supplemental Applications filing	SERFF Tr Num: FRCS-125860763	State: ArkansasLH
TOI: L08 Life - Other	SERFF Status: Closed	State Tr Num: 40626
Sub-TOI: L08.000 Life - Other	Co Tr Num: 4973	State Status: Approved-Closed
Filing Type: Form	Co Status: None	Reviewer(s): Linda Bird
	Authors: Exselsa Cartwright, Johnna Kemp	Disposition Date: 10/23/2008
	Date Submitted: 10/20/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: IAPINS/66	Status of Filing in Domicile: Not Filed
Project Number: 66	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filing not submitted to the domicile state.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 10/23/2008	
State Status Changed: 10/23/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

The enclosed forms will be used to supplement individual life insurance applications approved for use in your state.

Company and Contact

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Filing Contact Information

(This filing was made by a third party - FC01)

Johnna Kemp, Technician	johnna.kemp@firstconsulting.com	
1020 Central, Suite 201	(800) 927-2730 [Phone]	
Kansas City, MO 64105	(816) 391-2755[FAX]	

Filing Company Information

Industrial Alliance Pacific Insurance and Financial Services Inc.	CoCode: 84514	State of Domicile: Washington
2165 Broadway W.	Group Code:	Company Type:
Vancouver, BC V6K 4N5	Group Name:	State ID Number:
(604) 734-1667 ext. [Phone]	FEIN Number: 98-0018913	

Filing Fees

Fee Required?	Yes
Fee Amount:	$120.00
Retaliatory?	No
Fee Explanation:	The fee in you Department is 120.00per form filing. Therefore the fee for this filing will be $120.00.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Industrial Alliance Pacific Insurance and Financial Services Inc.	$120.00	10/20/2008	23348104

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/23/2008	10/23/2008

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Disposition

Disposition Date: 10/23/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		No
Form	Non-Medical Questionnaire		Yes
Form	Application for Child Rider		Yes
Form	Reinstatement/Change Application		Yes
Form	Supplementary Application		Yes
Form	Part II Application		Yes
Form	Financial Statement		Yes

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Form Schedule

Lead Form Number: FORM 9566-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	FORM 9566-AR	Application/ Enrollment Form	Non-Medical Questionnaire	Initial		73	9566-AR.pdf
	FORM 9587-AR	Application/ Enrollment Form	Application for Child Rider	Initial		47	9587-AR.PDF
	FORM 9589-AR	Application/ Enrollment Form	Reinstatement/Change Application	Initial		49	9589-AR.pdf
	FORM 9593-AR	Application/ Enrollment Form	Supplementary Application	Initial		50	9593-AR.pdf
	FORM 9605-AR	Application/ Enrollment Form	Part II Application	Initial		50	9605-AR.pdf
	FORM 9713-AR	Application/ Enrollment Form	Financial Statement	Initial		40	9713-AR.pdf

INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118

Non-Medical Questionnaire

Surname	Given Name	Date of Birth	Policy Number
		(M M / D D / Y Y Y Y)	

Agent's Name	Agent Code	Agency Name	Agency Code

1. ALCOHOL

Do you or have you ever used alcohol? ☐ Yes ☐ No

Give details for all affirmative answers:

If "Yes," answer the following questions:

(1 unit = 1 glass of wine = 1 bottle of beer = 1 ounce of alcohol)

a) Current number of units and frequency: _____ / day _____ / week

b) If there has been a reduction in alcohol consumption, enter the number of units and frequency before the reduction: (Specify date and reason)
_____ / day _____ / week

c) Treatment for alcohol use? (Dates and names of physicians or institutions) ☐ Yes ☐ No

d) Convicted for driving while under the influence of alcohol? (Specify date) ☐ Yes ☐ No

e) Are you a member of a support group? (Name? e.g., Alcoholics Anonymous) ☐ Yes ☐ No

2. DRUGS

In the past 10 years, have you been treated for drug abuse, used illegal drugs, or used prescription drugs other than as prescribed by a physician? ☐ Yes ☐ No

If "Yes," answer the following questions:

a) When did you start using drugs? Date: _____

b) Give reasons why you started using drugs: _____

_____

c) Indicate in the table below the drugs you have used in the past or are using at present.	Dosage or Amount Used	How Often Used	Dates Used From	To
1. OPIUM ("op"), HEROIN ("junk, horse, H, smack"), MORPHINE, CODEINE, DEMEROL, METHADONE ☐ Yes ☐ No				
2. BARBITURATES ("goof balls, downers, barbs, reds, yellows, jackets, candy, etc."), AMYTAL, PHENOBARBITAL, SECONAL, NEMBUTAL, PENTOBARBITAL ☐ Yes ☐ No				
3. MARIJUANA ("pot, grass, weed, joint, hash, cannabis, hemp, etc.") ☐ Yes ☐ No				
4. AMPHETAMINES ("speed, uppers, pep pills, wake-ups, etc."), BENZEDRINE, DEXEDRINE, METHEDRINE ☐ Yes ☐ No				
5. COCAINE ("crack, cane") ☐ Yes ☐ No				
6. HALLUCINOGENS: MESCALINE, LSD ("acid"), DMT, PEYOTE, PSILOCYBIN ☐ Yes ☐ No				
7. ANABOLIC STEROIDS ☐ Yes ☐ No				
8. OTHERS ☐ Yes ☐ No				

d) Have you ever been treated for drug use? ☐ Yes ☐ No

If "Yes," give the dates, names and addresses of physicians or institutions: _____

_____

e) If you are no longer using drugs, why did you stop? _____

f) Do you intend to use drugs in the future? ☐ Yes ☐ No

3. FOREIGN RESIDENCE

Do you intend to travel or live outside of the United States or Canada for more than a month? ☐ Yes ☐ No

If "Yes," answer the following questions:

a) Citizenship: _____ b) Departure date: _____

c) Foreign residence location (country, city): _____ d) Total duration of stay: _____

e) Reasons: _____

f) Type of employment: _____

g) Name of employer or organization in charge: _____

h) Have you ever lived abroad? ☐ Yes ☐ No

Specify location, duration, and date: _____

i) Over the next 5 years, will you likely live/travel abroad? ☐ Yes ☐ No

Specify location, duration, and date: _____

j) Beyond the next 5 years, will you likely live/travel abroad? ☐ Yes ☐ No

Specify location, duration, and date: _____

4. DRIVING RECORD

Within the past three years, have you had your driver's license suspended or revoked, or been convicted of, or plead guilty or *nolo contendere* to, five or more traffic violations?

☐ Yes ☐ No

If "Yes," complete the table and answer the following questions:

a)

Violation	Number of Convictions	Dates of Convictions	Points Taken from License
Unbuckled seat belt			
Speeding			
Failing to obey traffic lights			
Failing to stop or yield			
Illegal passing			
Accident – at fault			
Following too closely			
Others (specify)			

b) Has your driver's license ever been suspended or revoked as a result of the above violation(s)? ☐ Yes ☐ No

If "Yes," why? Accumulated points? ☐ Yes ☐ No

Unpaid fines? ☐ Yes ☐ No Amount: _____

Others? Specify: _____

Date you lost your license? _____ Duration? _____

Did you drive while your license was suspended? ☐ Yes ☐ No Dates: _____

When was your license returned, or when do you expect its return? _____

c) Have you ever been convicted of, or entered a plea of guilty or of *nolo contendere* to, driving under the influence of alcohol (DUI), driving while intoxicated (DWI), or driving while ability impaired (DWAI)? ☐ Yes ☐ No

If "Yes," Date of conviction/plea: _____

Did you drive while your license was suspended? ☐ Yes ☐ No Dates: _____

When was your license returned, or when do you expect its return? _____

d) Have you ever been convicted of, or entered a plea of guilty or of *nolo contendere* to: hit-and-run, reckless driving, vehicular homicide, vehicular manslaughter, negligent homicide, or negligent manslaughter? ☐ Yes ☐ No

If "Yes," Date: _____ Specify the violation: _____

Explain the circumstances: _____

Did you drive while your license was suspended? ☐ Yes ☐ No Dates: _____

When was your license returned, or when do you expect its return? _____

5. AVIATION

Have you ever made or intend to make aerial flights other than as a passenger? ☐ Yes ☐ No

If "Yes," answer the following questions:

a) Statement of hours flown and expected number of flight hours:

			NUMBER OF FLIGHT HOURS			
	Solo	With IFR or ATR	Hours accumulated	During the past 12 to 24 months	During the past 12 months	In the next 12 months
UNPAID FLIGHTS as a pilot, co-pilot, or an unpaid student						
PAID FLIGHTS as a member of the crew or an employee paid for duties performed during the flight. Give details.			Are the flights: ☐ Scheduled? ☐ Non Scheduled?			
MILITARY OR OTHER FLIGHTS as a member of the crew or in any other capacity. Give details.						

b) What kind of license do you have?

☐ Student ☐ Private Pilot ☐ Commercial Pilot ☐ Airline Pilot (ATR) ☐ Instructor

☐ Flight Instruments (IFR) ☐ None Date of Issue: _____

Has your license ever been suspended?

☐ Yes ☐ No If "Yes," give details: _____

c) What type of flights do you make?

☐ Pleasure ☐ Instructor ☐ Taxi, passenger ☐ Taxi, goods

☐ Crop-dusting ➔➔➔➔➔➔ ☐ with aircraft designed for crop-dusting ☐ Night flight

☐ Business Specify: _____ ☐ Other: _____

Over what areas are most flights made? _____

Who is the owner of the aircraft? _____ Who does the maintenance? _____

Type of aircraft? ☐ Single engine: # of passengers: _____ ☐ Multi-engine: # of passengers: _____ ☐ Helicopter

pounds of payload: _____ pounds of payload: _____ ☐ Glider

☐ Ultralight motorized ☐ Hot Air Balloon ☐ Motorized Hang-Glider ☐ Amateur built (Homebuilt)

☐ Freeflight

☐ Tethered

☐ Record attempts

Did you ever have an accident during a flight? ☐ Yes ☐ No If "Yes," give details: _____

d) When did you last fly? _____

Do you intend to continue flying? _____

Do you expect future flights to differ from those done in the past? ☐ Yes ☐ No If "Yes," give details: _____

SIGNATURE

I hereby declare that the above answers and statements form an integral part of my application to Industrial Alliance Pacific Insurance and Financial Services Inc., that they are full, complete, and true, and that no circumstance which might affect the risk of insurance on my life has been concealed.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____, on _____ 20____ _____

(City, State) Signature of Proposed Insured

Name	Surname	Date of Birth	Policy Number
		(M M / D D / Y Y Y Y)	

6. HAZARDOUS SPORTS *compulsory section*

Answer questions a) and b) and complete the appropriate section

a) In the last two years, have you taken part in any hazardous sports, such as:

- ☐ Skin or scuba diving
- ☐ Parachuting and/or skydiving
- ☐ Automotive sports
- ☐ Mountain climbing
- ☐ Hang gliding
- ☐ Rodeos

How long have you been practicing it (Frequency / month / year)? _____

When did you last practice this sport? _____

Are you a member of a club? ☐ Yes ☐ No If "Yes," specify: _____

Do you practice this sport as: ☐ an amateur ☐ as a professional

If professional, is it: ☐ full-time or ☐ part-time

Do you intend to continue practicing this sport? ☐ Yes ☐ No

Do you expect any changes in the participation in this sport? ☐ Yes ☐ No If "Yes," specify: _____

b) **Extra premium or restriction**

Should you not qualify for full coverage at standard rates, do you wish:

- ☐ To be covered for the sport you practice for an extra premium?
- ☐ Not to be covered for the hazardous sport you practice?

Skin or Scuba Diving

a) Give a brief description of the equipment you use: _____

b) Give a brief description of your diving habits (location, security measures, etc.): _____

_____

c) Do you dive alone? ☐ Yes ☐ No If "Yes," specify: _____

d) Have you ever suffered any ill effects due to diving? ☐ Yes ☐ No If "Yes," specify: _____

_____

e) Please give details of dives made during the past 3 years and an estimate for the next 12 months, by completing the following table:

PERIOD	DEPTH							
	50 ft. or less		51 ft. to 100 ft.		101 ft. to 150 ft.		151 ft. to _____	
	Number of dives	Number of hours	Number of dives	Number of hours	Number of dives	Number of hours	Number of dives	Number of hours
24 to 36 months ago								
12 to 24 months ago								
Last 12 months								
Next 12 months								

Parachuting and/or Skydiving

a) Check the type of parachuting you practice:

☐ Sport parachuting ☐ Parachuting with respiratory equipment
☐ Para-kiting ☐ Para-skiing
☐ Para-sailing ☐ Other, specify: _____

b) Number of jumps since you have been practicing this sport: _____

c) Are you making record attempts? ☐ Yes ☐ No If "Yes," specify: _____

Hang-Gliding

a) Maximum altitude less than 50 feet? ☐ Yes ☐ No

b) Are you using any equipment that is not manufactured, that is of an experimental nature or represents any other particular risks?
☐ Yes ☐ No If "Yes," specify: _____

c) Are you making record attempts? ☐ Yes ☐ No If "Yes," specify: _____

Mountain Climbing

Specify

☐ Rock climbing ☐ In North America
☐ Trail climbing ☐ Elsewhere, specify: _____

Automotive Sports

Check the appropriate items

a) Type of automobile races:

☐ Championship ☐ Stock car
☐ Sprinting (drag) ☐ Demolition
☐ Sports car ☐ Midget
☐ Other, specify: _____

b) Type of motorcycle races:

☐ Hill-climbing ☐ Sprinting (drag)
☐ Cross-country ☐ Moto-cross
☐ Other, specify: _____

c) Track:

☐ Oval shaped ☐ Other, specify: _____

d) Surface:

☐ Paved ☐ Unpaved
☐ Dirt road ☐ Other, specify: _____

e) Modified vehicle?

☐ Yes ☐ No If Yes, for safety? ☐ Yes ☐ No
for performance? ☐ Yes ☐ No

Mark: _____ Model: _____
Cylinders: _____ Horsepower: _____

f) Do you participate in races outside of Canada? ☐ Yes ☐ No If "Yes," specify: _____

g) Specify the names of tracks on which you race: _____

h) Maximum speed: m/h: _____ or km/hr: _____
Average speed: m/h: _____ or km/hr: _____

i) Reason for participating in race (pleasure, cash prizes, etc.):

_____

SIGNATURE

I hereby declare that the above answers and statements form an integral part of my application to Industrial Alliance Pacific Insurance and Financial Services Inc., that they are full, complete, and true, and that no circumstance which might affect the risk of insurance on my life has been concealed.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____, on _____ 20____ _____
(City, State) Signature of Proposed Insured

INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118
Tel: 425-646-6467 Fax: 604-682-2013

Application for Child Rider

To be included as part of new application on _____
(Proposed Insured on Basic Policy)

Or added to Policy No. _____

TELL US ABOUT THE CHILDREN

Full name of each Child to be insured (children, step children, and legally adopted children)	Sex M	Sex F	Insurance now in force in all companies	Date of Birth DD	Date of Birth MM	Date of Birth YYYY	Height	Weight

PLEASE ANSWER THESE HEALTH QUESTIONS

	No	Yes	If "Yes," give name of the child and full details.
1. With respect to the children,			
a) is this insurance intended to replace or change any insurance now or recently held in any company?	☐	☐	
b) has any application for insurance ever been declined, postponed, rated, or modified?	☐	☐	
2. Have any of the children had or have you been told they had:			If "Yes," give name of the child, specify the disease or disorder, and give history, dates, details, and names of doctors.
a) muscular dystrophy, cerebral palsy, or any other disease or disorder of the brain or nervous system?	☐	☐	
b) cystic fibrosis or any other disease or disorder of the lungs or respiratory system?	☐	☐	
c) Tetralogy of Fallot, Transportation of the Great Vessels, truncus arteriosus, total anomalous pulmonary venous drainage, artesias of the heart, or any other disease or disorder of the heart or blood vessels?	☐	☐	
d) any disease or disorder of the stomach, intestines, or bowels?	☐	☐	
e) any disease or disorder of the kidneys, liver, or bladder?	☐	☐	
f) any disease or disorder of the glands or blood?	☐	☐	
g) any disease or disorder of the skin, muscles, bones, or joints?	☐	☐	
h) any disease or disorder of the eyes, ears, nose, or throat?	☐	☐	
i) diabetes or sugar in the urine?	☐	☐	
j) cancer or tumor or any other growth?	☐	☐	
k) Down syndrome, paralysis, spina bifida, or any other abnormality, deformity disease or disorder?	☐	☐	
3. Are any of the children now receiving treatment or medication of any kind? If "Yes," give name of the child and details of the treatment or medication.	☐	☐	
4. Have any physicians or practitioners not mentioned above been consulted regarding any of the children for any reason not mentioned above?	☐	☐	
5. Within the past 10 years, have either parent or any of the children been diagnosed or treated by a physician or other health care professional as having acquired immunodeficiency syndrome (AIDS) or AIDS related complex (ARC) or positive test results indicating the presence of the AIDS virus?	☐	☐	
6. Have any of the child's natural parents, brothers, or sisters ever suffered from any of the following conditions: heart disease, stroke, high blood pressure, diabetes, multiple sclerosis, mental illness or suicide, kidney disease, cancer, tumors, Huntington's chorea, cystic fibrosis, muscular dystrophy, or any other hereditary disease?	☐	☐	
7. Do children (child) being insured under this Rider reside with you?	☐	☐	

8. If children (child) being insured are adopted, please indicate name of child and provide any medical information known about the natural parents:

Each of the undersigned declares that the statements and answers contained in this application are complete and true to the best of their knowledge and belief and that they shall form the basis of any insurance policy that may be issued. A copy of this application shall be attached to and made a part of the policy. The acceptance of any policy issued on this application shall constitute acceptance and ratification of any corrections made by the Company. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Applicants. **All information which I (We) have given to the agent is contained in this application. A misstatement of any question could result in policy rejection or rescission.** It is also agreed that the Company will incur no liability under this application until:

1. the application has been received and approved; **2.** a policy has been issued and delivered; and **3.** the full modal premium has been paid to and accepted by the Company.

The policy must be issued, delivered, and the full modal premium paid while the health, habits, avocations, and occupation of the Proposed Insured(s) are as stated in this application. The policy will then be deemed effective on its issue date. If the full modal premium specified in the application is paid on the date of this application, the liability of the Company shall be as stated on the Conditional Premium Receipt, which then becomes part of this application. The Company will notify the Applicants of its decision regarding the insurability of the Proposed Insured(s) within 60 days of receipt of the application. Otherwise, it will notify the Applicants of the reason for any further delay.

No agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Dated at _____ this _____ day of _____ 20_____
(City, State) (Month)

_____ _____
Signature of Licensed Agent / Witness Signature of Applicant (Parent or Legal Guardian of Child)

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. Industrial Alliance Pacific Insurance and Financial Services Inc., its reinsurers, insurance support organizations and their authorized representatives, may obtain medical and other information in order to evaluate my (our) minor child's (children's) application for insurance.

B. Any physician, practitioner, hospital, clinic, other medically related facility, the Veterans Administration, the Medical Information Bureau Inc. (MIB), and consumer reporting agency or insurance company who possesses information of care, treatment, or advice of my minor child (children) may furnish such information to Industrial Alliance Pacific Insurance and Financial Services Inc. or its representative upon presenting this authorization or a photocopy.

C. This authorization includes information about drugs, alcoholism, or mental illness.

D. Industrial Alliance Pacific Insurance and Financial Services Inc. or its reinsurers may make a brief report to MIB regarding my minor child (children).

E. I authorize Industrial Alliance Pacific Insurance and Financial Services Inc. to obtain an investigative consumer report on my child (children).

F. I have read this Authorization and understand that I or any person authorized to act on my behalf is entitled to receive a copy of it, if so requested. I have also received copies of the "Notice Regarding MIB", "Notice Under the Fair Credit Reporting Act" and "Industrial Alliance Pacific Insurance and Financial Services Inc. Description of Information Practices" with my original application. I understand that Industrial Alliance Pacific Insurance and Financial Services Inc. will furnish additional copies of these notices upon request.

G. This authorization will be valid from the date signed for a period of two and one half years. A photographic copy of this authorization shall be as valid as the original.

H. ☐ I elect to be interviewed if an investigative consumer report is prepared in connection with this application.

Signed this _____ day of _____ 20_____
(Month)

Signature of Minor Children if age 15 and above

_____ _____
(Signature of Applicant)

_____

_____ _____
(Signature of Spouse)

Witness: _____
(Agent's Signature)

A COPY OF THIS AUTHORIZATION IS AVAILABLE TO THE APPLICANT OR THE APPLICANT'S AUTHORIZED REPRESENTATIVE ON REQUEST.

INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118

APPLICATION for REINSTATEMENT / CHANGE

1. POLICY THIS REQUEST APPLIES TO

Full Name of Policyowner: _____ Policy Number: _____

Full Name of Insured: _____

A SEPARATE APPLICATION IS REQUIRED FOR EACH INSURED

2. TELEPHONE AND MAILING ADDRESS

Number and Street: _____ Tel. No.: (___) _____

City: _____ State: _____ ZIP: _____–_____ Fax No.: (___) _____

3. REASON FOR APPLICATION

When requesting any of the following, complete only 6. AGREEMENT.

☐ Change Death Benefit Option from 2 to 1 ☐ Decrease face amount to: $ _____

☐ Conversion to: _____

When requesting any of the following, complete 4. GENERAL QUESTIONS, 5. DECLARATION OF INSURABILITY, and 6. AGREEMENT. Remove, read, and retain the notice at the bottom of last page.

☐ Reinstatement ☐ Change rating

☐ Change Death Benefit Option from 1 to 2 ☐ Change to Non-smoker / Non-tobacco rates

☐ Increase face amount to: $ _____ ☐ Other: _____

☐ Change plan of insurance to: _____ _____

_____ _____

4. GENERAL QUESTIONS

A. Insured

Height ____ ft. ____ in. Weight ____ lbs. Pounds lost in past 12 months ____. Reason? _____

For "Yes" answers, provide details and/or complete applicable section on Non-Medical Questionnaire.

B. Have you used any form of tobacco or nicotine products in the past 12 months? ☐ Yes ☐ No

C. Within the past 5 years, have you flown as a student, private, commercial, military, or test pilot or do you have plans for such flights in the future? (If "Yes," complete Aviation section of Non-Medical Questionnaire) ☐ Yes ☐ No

D. Within the past 5 years, have you participated in or do you intend to participate in any form of motorized racing, scuba or sky diving, rock or mountain climbing, or any other hazardous sports? (If "Yes," complete Hazardous Sports section of Non-Medical Questionnaire) ☐ Yes ☐ No

E. Within the past 5 years, have you had a citation for a traffic violation? (If "Yes," also provide driver's license number in details section) ☐ Yes ☐ No

F. Within the past 5 years, have you been convicted of a felony or misdemeanor or do you have charges currently pending? ☐ Yes ☐ No

G. Do you intend to travel or reside outside the U.S. or Canada for more than one month? (If "Yes," provide full details on destination and length of stay) ☐ Yes ☐ No

H. Do you have an application for life or health insurance pending or have you applied for such insurance within the past 6 months? (If "Yes," are all policies to be accepted?) ☐ Yes ☐ No

I. Within the past 5 years, have you had an application (including a reinstatement application) for life or health insurance declined, rated, modified or postponed? ☐ Yes ☐ No

J. Is this policy to replace any existing insurance or annuity? (If "Yes," indicate which policy) ☐ Yes ☐ No

K. Do you currently have any insurance in force (If "YES," list all policies below)? ☐ YES ☐ NO

COMPANY	AMOUNT	A.D.B.	YEAR ISSUED	REPLACEMENT
				☐ Yes ☐ No
				☐ Yes ☐ No

L. Complete only if Proposed Insured is a minor

i) Are all siblings being insured? ☐ Yes ☐ No

ii) Sum insured of existing life insurance on parents: $ _____ $ _____ ☐ None

iii) If i) is "No" or ii) is "None," provide reason: _____

Details and Additional Instructions

Corrections and Notations made by Home Office

5. DECLARATION OF INSURABILITY

A. I. Name, address, and phone number of the physician or medical facility who will have your medical records:

(Please provide medical record number, if available.)

II. Date, reason for, and results of the last visit made to the above physician or medical facility:

Proposed Insured

B. Do you currently take any medication regularly or as needed? (If "Yes," provide details)..... ☐ Yes ☐ No

C. In the past ten years, have you had, been tested for, received treatment or counseling from a medical professional for, or been told you have: (Circle appropriate item and provide details)

a) Dizziness, fainting, convulsions, epilepsy, paralysis, stroke, or severe headaches? ..... ☐ Yes ☐ No

b) Depression, anxiety, mental or nervous disorder? ..... ☐ Yes ☐ No

c) Shortness of breath, bronchitis, emphysema, asthma, pleurisy, or persistent cough? ..... ☐ Yes ☐ No

d) Chest pain, angina, palpitations, irregular heart beat, high blood pressure, heart attack, or coronary artery disease? ..... ☐ Yes ☐ No

e) Heart murmur, heart valve disorder, edema, or disorder of the heart or blood vessels? ..... ☐ Yes ☐ No

f) Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, intestines, spleen, liver, or rectum? ..... ☐ Yes ☐ No

g) Diabetes, high blood sugar, or sugar in your urine?..... ☐ Yes ☐ No

h) Blood or protein in your urine, any disorder of the kidneys, bladder, prostate, or urinary system?..... ☐ Yes ☐ No

I) Any disease or disorder of the reproductive system? ..... ☐ Yes ☐ No

j) Thyroid, thymus, pituitary, or lymph gland disorder?..... ☐ Yes ☐ No

k) Cancer, sarcoidosis, tumor, or any abnormal growth? ..... ☐ Yes ☐ No

l) Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints?..... ☐ Yes ☐ No

m) Multiple sclerosis, or any disorder of the brain or spinal cord?..... ☐ Yes ☐ No

n) Hemophilia, sickle cell anemia, anemia, or any disorder of the blood (other than HIV related)?..... ☐ Yes ☐ No

o) Alcoholism, drug addiction, or excessive use of alcohol or drugs? ..... ☐ Yes ☐ No

D. In the past ten years, have you:

a) been diagnosed or treated by a physician or other health care professional as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC), or positive test results indicating the presence of the AIDS virus? ..... ☐ Yes ☐ No

b) used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician? ..... ☐ Yes ☐ No

Details to "Yes" answers (include dates and physicians or medical facility address)

6. AGREEMENT

The undersigned declares that the statements and answers contained in this application are complete and true to the best of their knowledge and belief, that the answers were correctly recorded before we signed below, and that they shall form the basis of any insurance policy that may be issued. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Proposed Insured and/or the Owner. **A misstatement of any question could result in policy rejection or rescission. Any person who, with intent to defraud or knowing that they are facilitating a fraud, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

It is also agreed that the Company will incur no liability under this application until the application has been received and approved and the full modal premium has been paid to and accepted by the Company at its Home Office.

The Company will notify the Applicant of its decision regarding the insurability of the Proposed Insured within 60 days of receipt of the application. Otherwise, it will notify the Applicant of the reason for any further delay.

No agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

The applicant acknowledges receipt of the "Notice of Insurance Information Practices," "Fair Credit Reporting Act," and the "Medical Information Bureau Notice."

If this is a request for a change to this policy and if the Policyowner lives in a community property state, this request must be signed by the spouse. If this form is received without the spouse's signature, this will be your declaration that this policy is not community property, which will release Industrial Alliance Pacific Insurance and Financial Services Inc. of any community property liability.

If this policy is owned by a third party, the Owner must sign the application on the line provided.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ this _____ day of _____ 20_____
(City, State) (Month)

_____ _____
Signature of Insured (Parent or Guardian if under age 16) | Signature of Witness or Owner (if Owner is other than Insured)

Disclosure Statement

One of the prime objectives of Industrial Alliance Pacific Insurance and Financial Services Inc., is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure each policyholder contributes his/her fair share of the cost. In considering an application, information from various sources must, therefore, be considered for insurance on your life. These include the results of your physical examination, if required, and any reports received from doctors and hospitals who have attended the individuals whose lives are to be insured.

Notice of Insurance Information Practices

To evaluate your application for insurance, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than you. This is done with your consent. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. Although the information we obtain about you is confidential, in some cases we may disclose information to others, but only to further the underwriting, issuance, and management of the specific product for which you are applying. We will furnish a more detailed summary of our information practices upon request.

Fair Credit Reporting Act Notice

As part of our evaluation of the application for insurance on your life, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors, or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related directly or indirectly to your sexual orientation.

Upon your written request and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

THIS MUST BE GIVEN TO THE INDIVIDUALS WHOSE LIVES ARE TO BE INSURED AND WHERE ANY SUCH INDIVIDUAL(S) IS A MINOR, TO THE PARENT OR LEGAL GUARDIAN OF SUCH INDIVIDUAL

(see over)

Authorization to Obtain Information

The undersigned authorizes in respect of himself or herself any or all of the following:

(a) Any physician or medical practitioner;
(b) hospital, clinic, medical or medically related facility;
(c) insurance or reinsurance company;
(d) the Medical Information Bureau;
(e) consumers reporting agencies;
(f) employers,

having any records or knowledge of me or my health, or my minor children's health, to give to Industrial Alliance Pacific Insurance and Financial Services Inc., or its reinsurers, any such information including alcohol, drug, and psychiatric information.

Information obtained with this authorization may only be:

(a) used to determine insurability;
(b) released to reinsurance companies;
(c) sent to the Medical Information Bureau;
(d) sent to persons or organizations performing business or legal services in connection with my application, except for information received from the Medical Information Bureau, which must not be disclosed;
(e) used as lawfully required;
(f) used as I may further authorize in writing.

The undersigned acknowledges receipt of the "Notice of Insurance Information Practices" and agrees that a photographic copy of this Authorization shall be as valid as the original. The undersigned agrees that this Authorization shall be valid for two and one half years from the date shown below.

Each of the undersigned requests that any examination findings relating to such undersigned resulting in a rating, postponement, or declination of any or all coverage requested on this application be forwarded directly to:

Such undersigned's Regular Physician ☐ Yes ☐ No

Such undersigned's Attention at his/her Home Address ☐ Yes ☐ No

Each of the undersigned elects to be interviewed if an investigative consumer report is prepared in connection with this application ☐ Yes ☐ No

Date _____ Signature of Proposed Insured/Owner _____
(Parent or Legal Guardian if Proposed Insured/Owner is a minor)

A COPY OF THIS AUTHORIZATION IS AVAILABLE TO THE APPLICANT OR THE APPLICANT'S AUTHORIZED REPRESENTATIVE ON WRITTEN REQUEST.

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We may however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. If another application for insurance on your life is made to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon request, will furnish that company with information about you from its files.

We may also release information in our file to other life insurance companies to whom application is made for insurance on your life or health or to whom a claim for benefits may be submitted.

Upon your request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the Bureau's files, you may seek correction from the Bureau as provided by the Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Their telephone number is (617) 426-3660.

INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118

SUPPLEMENTARY APPLICATION

Print using dark ink

Section 1 – PROPOSED INSURED

First name: _____ Middle initial: ____ Last name: _____

Sex: ☐ Male ☐ Female Date of birth: ____ (M M / D D / Y Y Y Y) Age: ____ Place of birth: _____

SSN: _____ Occupation: _____

Home address: _____ How long: _____ Home Tel. No.: ( ) _____

City: _____ State: _____ ZIP: _____

Employer: _____ Annual Income: _____ How long: _____

Employer's address: _____ Tel. No.: ( ) _____

City: _____ State: _____ ZIP: _____

Section 2 – BENEFICIARY

☐ **Primary _____ %**

Full name: _____ Tax ID or SSN: _____

Relationship to Proposed Insured: _____ Date of Birth: ____ (M M / D D / Y Y Y Y)

Address: _____ Tel. No.: ( ) _____

City: _____ State: _____ ZIP: _____

☐ **Primary _____ %** ☐ **Contingent**

Full name: _____ Tax ID or SSN: _____

Relationship to Proposed Insured: _____ Date of Birth: ____ (M M / D D / Y Y Y Y)

Address: _____ Tel. No.: ( ) _____

City: _____ State: _____ ZIP: _____

☐ **Primary _____ %** ☐ **Contingent**

Full name: _____ Tax ID or SSN: _____

Relationship to Proposed Insured: _____ Date of Birth: ____ (M M / D D / Y Y Y Y)

Address: _____ Tel. No.: ( ) _____

City: _____ State: _____ ZIP: _____

Section 3 – POLICY DETAILS: BASIC DATA – PROPOSED INSURED

☐ **MULTIFLEX** ☐ **OTHER**

Face amount: $ _____

Term Rider: ☐ T10 or ☐ T20

☐ Accidental Death for $ _____
(Maximum $150,000)

☐ Preferred Non-tobacco ($100,000 minimum) **Complete pre-qualification questionnaire.**

Section 4 – GENERAL QUESTIONS

A. Proposed Insured

Height: ____ ft. ____ in. Weight: ____ lbs. Pounds lost in past 12 months: ____. Reason? _____

For "Yes" answers, provide details and/or complete applicable section on Non-Medical Questionnaire.

B. Have you used any form of tobacco or nicotine products in the past 12 months? ..... ☐ Yes ☐ No

C. Within the past 5 years, have you flown as a student, private, commercial, military, or test pilot, or do you have plans for such flights in the future? (If "Yes," complete Aviation section of Non-Medical Questionnaire) ..... ☐ Yes ☐ No

D. Within the past 5 years, have you participated in, or do you intend to participate in, any form of motorized racing, scuba or sky diving, rock or mountain climbing, or any other hazardous sports? (If "Yes," complete Hazardous Sports section of Non-Medical Questionnaire) ..... ☐ Yes ☐ No

E. Within the past 5 years, have you had a citation for a traffic violation? (If "Yes," also provide driver's license number in details section) ..... ☐ Yes ☐ No

F. Within the past 5 years, have you been convicted of a felony or misdemeanor, or do you have charges currently pending? ..... ☐ Yes ☐ No

G. Do you intend to travel or reside outside the US or Canada for more than one month? (If "Yes," provide full details on destination and length of stay) ..... ☐ Yes ☐ No

H. Do you have an application for life or health insurance pending, or have you applied for such insurance within the past 6 months? (If "Yes," are all policies to be accepted?) ..... ☐ Yes ☐ No

I. Within the past 5 years, have you had an application (including a reinstatement application) for life or health insurance declined, rated, modified, or postponed? ..... ☐ Yes ☐ No

J. Is this policy to replace any existing insurance or annuity? (If "Yes," indicate which policy) ..... ☐ Yes ☐ No

K. Do you currently have any insurance in force (If "YES," list all policies below) ☐ YES ☐ NO

COMPANY	AMOUNT	A.D.B.	YEAR ISSUED	REPLACEMENT
				☐ Yes ☐ No
				☐ Yes ☐ No

L. Complete only if proposed insured is a minor

i) Are all siblings being insured? ☐ Yes ☐ No

ii) Sum insured of existing life insurance on parents? $ _____ $ _____ ☐ None

iii) If i) is "No" or ii) is "None," provide reason: _____

Details and Additional Instructions

Corrections and Notations made by Home Office

Section 5 – Complete all questions if no Paramedical is required and only questions 1A, B & 2 if a Paramedical is required.

1. A. Name, address, and phone number of the physician or medical facility who will have your medical records:

(Please provide medical record number, if available.)

B. Date, reason for, and results of the last visit made to the above physician or medical facility:

Proposed Insured

---

2. Do you currently take any medication regularly or as needed? (If "Yes," provide details)..... ☐ Yes ☐ No

3. In the past ten years, have you had, been tested for, received treatment or counseling from a medical professional for, or been told you have: (Circle appropriate item and provide details)

a) Dizziness, fainting, convulsions, epilepsy, paralysis, stroke, or severe headaches? ..... ☐ Yes ☐ No

b) Depression, anxiety, mental or nervous disorder? ..... ☐ Yes ☐ No

c) Shortness of breath, bronchitis, emphysema, asthma, pleurisy, or persistent cough? ..... ☐ Yes ☐ No

d) Chest pain, angina, palpitations, irregular heart beat, high blood pressure, heart attack, or coronary artery disease? ..... ☐ Yes ☐ No

e) Heart murmur, heart valve disorder, edema, or disorder of the heart or blood vessels? ..... ☐ Yes ☐ No

f) Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, intestines, spleen, liver, or rectum? ..... ☐ Yes ☐ No

g) Diabetes, high blood sugar, or sugar in your urine?..... ☐ Yes ☐ No

h) Blood or protein in your urine, any disorder of the kidneys, bladder, prostate, or urinary system?..... ☐ Yes ☐ No

I) Any disease or disorder of the reproductive system? ..... ☐ Yes ☐ No

j) Thyroid, thymus, pituitary, or lymph gland disorder?..... ☐ Yes ☐ No

k) Cancer, sarcoidosis, tumor, or any abnormal growth? ..... ☐ Yes ☐ No

l) Back pain, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints?..... ☐ Yes ☐ No

m) Multiple sclerosis, or any disorder of the brain or spinal cord?..... ☐ Yes ☐ No

n) Hemophilia, sickle cell anemia, anemia, or any disorder of the blood (other than HIV related)?..... ☐ Yes ☐ No

o) Alcoholism, drug addiction, or excessive use of alcohol or drugs? ..... ☐ Yes ☐ No

4. In the past ten years, have you:

a) been diagnosed or treated by a physician or other health care professional as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC), or positive test results indicating the presence of the AIDS virus? ..... ☐ Yes ☐ No

b) used marijuana, cocaine, heroin, or narcotics not prescribed to you by a physician?..... ☐ Yes ☐ No

Details to "Yes" answers (include dates and physicians or medical facility address)

AGREEMENT

Each of the undersigned declares that the statements and answers contained in this application and provided by such individuals are complete and true to the best of his/her knowledge and belief, that the statements and answers were correctly recorded before he/she signed below, and that they shall form the basis of any insurance policy that may be issued. A copy of this application shall be attached to and made a part of the policy. The acceptance of any policy issued on this application shall constitute acceptance and ratification of any corrections made by Industrial Alliance Pacific Insurance and Financial Services Inc. ("the Company") in the section entitled Corrections and Notations made by Home Office of this application. No change in amount, classification, plan of insurance, or benefits shall be effective unless agreed to in writing by the Proposed Insured and/or the Policyowner. **All information which I(We) have given to the agent is contained in this application. A misstatement of any question could result in policy rejection or rescission.**

It is also agreed that the Company will incur no liability under this application until:

1. the application has been received and approved;
2. a policy has been issued and delivered; and
3. the full modal premium has been paid to and accepted by the Company at its Home Office.

The policy must be issued, delivered, and the full modal premium paid while the health, habits, avocations, and occupation of the lives to be insured are as stated in this application. The policy will then be deemed effective on its issue date.

The Company will notify the Policyowner of its decision regarding the insurability of the lives to be insured, as stated in this application, within 60 days of receipt of the application. Otherwise, it will notify the Policyowner of the reason for any further delay.

No agent has the authority to waive the answers to any of the questions in this application or to make or alter any contract for the Company.

Each of the lives to be insured, as stated in this application, acknowledges receipt of the "Notice of Insurance Information Practices," "Fair Credit Reporting Act," and the "Medical Information Bureau Notice."

The Agent and Policyowner agree that no insurance other than those policies for the indicated life or lives to be insured indicated as replacements in Section 4(K) will be replaced by a policy issued in connection with this application.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____ this _____ day of _____ 20_____
(City, State) (Month)

_____ _____
Signature of Proposed Insured
(Parent or Legal Guardian if Proposed Insured is under 16)

Signature of Policyowner
(If other than Proposed Insured)

_____ _____ _____
Signature of Licensed Agent (Witness) Print Agent Name Agent # / %

Authorization to Obtain Information

The undersigned authorizes, in respect of himself or herself, any or all of the following:

(a) Any physician or medical practitioner;
(b) hospital, clinic, medical or medically related facility;
(c) insurance or reinsurance company;
(d) the Medical Information Bureau;
(e) consumers reporting agencies;
(f) employers,

having any records or knowledge of me or my health, or my minor children's health, to give to Industrial Alliance Pacific Insurance and Financial Services Inc., or its reinsurers, any such information, including alcohol, drug, and psychiatric information.

Information obtained with this authorization may only be:

(a) used to determine insurability;
(b) released to reinsurance companies;
(c) sent to the Medical Information Bureau;
(d) sent to persons or organizations performing business or legal services in connection with my application, except for information received from the Medical Information Bureau, which must not be disclosed;
(e) used as lawfully required;
(f) used as I may further authorize in writing.

The undersigned acknowledges receipt of the Notice of Insurance Information Practices and agrees that a photographic copy of this Authorization shall be as valid as the original. The undersigned agrees that this Authorization shall be valid for two and one half years from the date shown below.

Each of the undersigned requests that any examination findings relating to such undersigned resulting in a rating, postponement, or declination of any or all coverage requested on this application be forwarded directly to:

Such undersigned's Regular Physician ☐ Yes ☐ No

Such undersigned's Attention at his/her Home Address ☐ Yes ☐ No

Each of the undersigned elects to be interviewed if an investigative consumer report is prepared in connection with this application ☐ Yes ☐ No

Date _____ Signature of Proposed Insured/Owner _____
(Parent or Legal Guardian if Proposed Insured/Owner is a minor)

A COPY OF THIS AUTHORIZATION IS AVAILABLE TO THE APPLICANT'S OR THE APPLICANTS' AUTHORIZED REPRESENTATIVE ON WRITTEN REQUEST.

Disclosure Statement

One of the prime objectives of Industrial Alliance Pacific Insurance and Financial Services Inc. is to provide insurance at low cost. The underwriting process (evaluation of risks) is necessary not only to assure this low cost, but also to assure each policyholder contributes his/her fair share of the cost. In considering an application, information from various sources must, therefore, be considered for insurance on your life. These include the results of your physical examination, if required, and any reports received from doctors and hospitals who have attended the individuals whose lives are to be insured.

Notice of Insurance Information Practices

To evaluate your application for insurance, we will need some personal information about you. It may be necessary to obtain some of that information from sources other than you. This is done with your consent. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information. Although the information we obtain about you is confidential, in some cases we may disclose information to others, but only to further the underwriting, issuance, and management of the specific product for which you are applying. We will furnish a more detailed summary of our information practices upon request.

Fair Credit Reporting Act Notice

As part of our evaluation of the application for insurance on your life, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors, or others with whom you are acquainted or who may have information about you. This report, among other things, may include information as to your character, general reputation, personal characteristics, health, and mode of living, except as may be related directly or indirectly to your sexual orientation.

Upon your written request and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation, and to receive a copy of the report at your expense.

THIS MUST BE GIVEN TO THE INDIVIDUALS WHOSE LIVES ARE TO BE INSURED AND WHERE ANY SUCH INDIVIDUAL(S) IS A MINOR, TO THE PARENT OR LEGAL GUARDIAN OF SUCH INDIVIDUAL

(see over)

Medical Information Bureau Notice

Information regarding your insurability will be treated as confidential. We may however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. If another application for insurance on your life is made to another Bureau member for life or health insurance or if a claim is made to such a company, the Bureau, upon request, will furnish that company with information about you from its files.

We may also release information in our file to other life insurance companies to whom application is made for insurance on your life or health or to whom a claim for benefits may be submitted.

Upon your request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the Bureau's files, you may seek correction from the Bureau as provided by the Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Their telephone number is (617) 426-3660.

INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118
Tel: (425) 646-6467 Fax: (604) 682-2013

PART 2 OF APPLICATION

1. Name of Proposed Insured: _____ Date of Birth: (M M / D D / Y Y Y Y) Sex: ❑ M ❑ F

2. a) Name and address of your usual physician or medical facility:

b) Date and reason last consulted:

c) Results, diagnosis, and/or treatment prescribed:

	Yes	No	Details of "YES" answers: (Please identify applicable question and include dates, diagnosis, duration, treatment, as well as the full name and address of all physicians and medical facilities.)
3. In the past ten years, have you had, been tested for, received treatment or counseling from a medical professional for:			
a) Dizziness, fainting, convulsions, seizures, epilepsy, speech disorder, paralysis, stroke, or severe headaches?	❑	❑	
b) Depression, anxiety, mental or nervous disorder?	❑	❑	
c) Shortness of breath, bronchitis, emphysema, tuberculosis, asthma, spitting of blood, pleurisy, or persistent cough?	❑	❑	
d) Chest pain, angina, palpitations, irregular heart beat, high blood pressure, heart attack, or coronary artery disease?	❑	❑	
e) Rheumatic fever, heart murmur, heart valve disorder, edema, or disorder of the heart or blood vessels?	❑	❑	
f) Ulcer, intestinal bleeding, colitis, ulcerative colitis, Crohn's disease, jaundice, hernia, diarrhea, hepatitis, or any disorder of the stomach, intestines, spleen, liver, or rectum?	❑	❑	
g) Diabetes, high blood sugar, or sugar in your urine?	❑	❑	
h) Blood cells, albumin, or protein in your urine, any disorder of the kidneys, bladder, prostate, or urinary system?	❑	❑	
i) Venereal disease or any disorder of the reproductive system?	❑	❑	
j) Thyroid, thymus, pituitary, or lymph gland disorder?	❑	❑	
k) Cancer, sarcoidosis, tumor, or any abnormal growth?	❑	❑	
l) Back pain, sciatica, neuritis, rheumatism, arthritis, muscular dystrophy, or any disorder of the muscles, bones, or joints?	❑	❑	
m) Multiple sclerosis, or any disorder of the brain or spinal cord?	❑	❑	
n) Hemophilia, sickle cell anemia, anemia, or any disorder of the blood?	❑	❑	
o) Alcoholism, or excessive use of alcohol or drugs?	❑	❑	
4. In the past ten years, have you:			
a) been diagnosed or treated by a physician or other health care professional as having acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC), or positive test results indicating the presence of the AIDS virus?	❑	❑	

		Yes	No	Details of "YES" answers: (Please identify applicable question and include dates, diagnosis, duration, treatment, as well as the full name and address of all physicians and medical facilities.)
5.	Have you used any form of tobacco or nicotine products:			
	a) In the past 36 months?	❑	❑	
	b) In the past 12 months?	❑	❑	
6.	Have you ever used marijuana, hash, cocaine, heroin, or narcotics not prescribed to you by a physician?	❑	❑	
7.	Other than the above, within the past 5 years, have you had:			
	a) An examination or treatment by a doctor or medical practitioner?	❑	❑	
	b) Observation or treatment at a clinic, hospital, or other facility?	❑	❑	
	c) An EKG, stress test, x-ray, blood test, or any other diagnostic test?	❑	❑	
	d) A surgical operation or been advised to have a surgical operation?	❑	❑	
	e) A change of weight, anorexia nervosa, or bulimia?	❑	❑	
8.	a) If female, are you currently pregnant?	❑	❑	
	b) Have you ever had any complications with this or previous pregnancies?	❑	❑	
	c) Any disorders of the breast?	❑	❑	
9.	a) Do you have a family history of diabetes, cancer, stroke, kidney disease, high blood pressure, coronary artery disease, Huntington's chorea, alcoholism, drug abuse, or mental illness?	❑	❑	
	b) Have you ever received disability benefits from any source?	❑	❑	

I hereby declare that the answers and statements contained in this Part 2 application are full, complete, and true to the best of my knowledge and belief, and that the answers were correctly recorded before I signed below. I understand and agree that this Part 2 application shall be part of my application for insurance and will form part of the policy contract.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at: _____ Date: (M M / D D / Y Y Y Y)

City, State/Province

Witness: _____ Proposed Insured: _____

Signature of examiner

MEDICAL EXAMINERS REPORT

This section to be completed by all examiners.

All Proposed Insureds must be weighed and measured.

10. a) Height: _____

b) Weight: _____

Weight change in past year? _____

❑ Gain ❑ Loss

Cause? _____

11. Blood pressure:

Systolic: 1 _____ 2 _____ 3 _____

Diastolic: 1 _____ 2 _____ 3 _____

If blood pressure is over 140/90, take 3 readings at least 5 minutes apart.

12. Pulse: _____

Rhythm: _____

Irregularities? _____

If pulse is over 90, repeat in 5–10 minutes

13. Urinalysis:

Please indicate test results in the space provided. (This section to be completed on all examinations)

Albumin: _____

Glucose: _____

Blood: _____

Please forward urine sample to LABONE for microurinalysis.

14. Does the Proposed Insured appear older than the stated age?

❑ Yes ❑ No

15. Is there any evidence of alcohol, drug, or nicotine addiction?

❑ Yes ❑ No

This section to be completed by Physician only.

	YES	NO
16. Any evidence of past or present disease of:		
a) The brain or nervous system? (Test reflexes and coordination)	❑	❑
b) Head or neck? (Including ears, eyes, and mouth)	❑	❑
c) Endocrine system, breast, or glands?	❑	❑
d) Chest and lungs? (Examine on bare chest with expiratory cough)	❑	❑
e) Heart and blood vessels?	❑	❑
f) Abdomen? (Liver, spleen, abnormal masses, tenderness, surgical scars)	❑	❑
g) Genito-Urinary system? (Include prostate)	❑	❑
h) Musculoskeletal system? (Include spine/joint deformities)	❑	❑
i) Skin (Xanthomas, nevi, etc.), lymph nodes?	❑	❑
17. Is there:		
a) Evident arteriosclerosis?	❑	❑
b) Cardiac hypertrophy?	❑	❑
c) Cyanosis, dyspnea, or edema?	❑	❑
d) Cardiovascular impairment?	❑	❑
e) Any hernias or varicosities?	❑	❑
f) A heart murmur? (Complete heart chart)	❑	❑

18. Heart Chart

Murmur

Location: ❑ Apical ❑ Aortic ❑ Mitral ❑ Pulmonic

Timing: ❑ Systolic ❑ Diastolic ❑ Pre-systolic

Intensity: ❑ Soft ❑ Moderate ❑ Loud

Grade: I II III IV V VI

Is murmur constant? ❑ Yes ❑ No

Transmitted? ❑ Yes ❑ No

If transmitted, indicate where to: _____

Effect of exercise: ❑ Unchanged ❑ Decreased ❑ Increased ❑ Disappears

Your impression of murmur: _____

Mail exam to:

Industrial Alliance Pacific
Insurance and Financial Services Inc.
P.O. Box 8118
Blaine, WA 98231-8118

19. Did you require an interpreter to question the Proposed Insured? ❑ Yes ❑ No

If "Yes,' indicate interpreter's name and relationship to Proposed Insured: _____

20. How was client identified? (driver license, etc.) _____

Remarks (please comment fully on any abnormal findings and details of "Yes" answers)

I certify that I made this examination at:
- ❑ Proposed Insured's home
- ❑ Office
- ❑ Other _____

Signed at: _____ Date: _____ (M M / D D / Y Y Y Y) Time: _____

City, State

_____

Signature of examiner

INDUSTRIAL ALLIANCE *PACIFIC*
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118

Confidential Financial Supplement

General Instructions:

– to be submitted with applications for $1,000,000 and up or at underwriter's discretion.
– complete Part I in all instances.
– complete Part II for personal insurance, Part III for business insurance.

For amounts **over $2 million also** submit audited financial statements* (personal or business, depending on the purpose of the insurance).

* for personal insurance, a year-end review by the personal accountant; for business insurance, such audited documents as income statements, profit & loss statements, balance sheets, and year-end financial reviews.

Proposed Insured _____ Birth Date _____

PART I – GENERAL

LIFE INSURANCE

In Force	Personal	Business	Purpose of Business Insurance
Life	$ _____	$ _____	_____
Accidental Death	$ _____	$ _____	_____
Annual Premium	$ _____	$ _____	_____

Pending or Contemplated

Amount	Name of Insurance Company(s)	Purpose
$ _____	_____	_____
$ _____	_____	_____
$ _____	_____	_____

Will any of this insurance be placed in addition to Industrial Alliance Pacific's?

❑ Yes (explain) _____

❑ No

PERSONAL INCOME

Current Year	Last Year	
$ _____	_____	Annual Earned Income (salary, wages, bonus, commissions)
$ _____	_____	Other Income (dividends, interest)
$ _____	_____	Total Income

BANKRUPTCY: Have you been involved in any kind of bankruptcy in the past 7 years?

❑ Yes (Give full details, including dates.) _____

❑ No

These financial disclosures are made for the purpose of establishing the value of my insurability. They are furnished as a true and accurate statement of current financial conditions.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Writing Agent	Date	Proposed Insured

INDUSTRIAL ALLIANCE PACIFIC
INSURANCE AND FINANCIAL SERVICES™

Industrial Alliance Pacific
Insurance and Financial Services Inc.
Box 8118, Blaine, WA 98231-8118

Confidential Financial Supplement

PART II – PERSONAL INSURANCE

PURPOSE OF COVERAGE

- ❑ Income replacement/family protection
- ❑ Estate conservation
- ❑ Debt repayment (give full details) _____
- ❑ Other (give full details) _____

PERSONAL WORTH

Assets		Liabilities	
$ _____	Cash in bank	$ _____	Bank loans
$ _____	Stocks and bonds	$ _____	Notes and accounts payable
$ _____	Notes and accounts receivable	$ _____	Insurance policy loans
$ _____	Real estate (residence)	$ _____	Taxes and interest due
$ _____	Real estate (other)	$ _____	Mortgages due
$ _____	Value of business (complete business Part III)	$ _____	Other (specify)
$ _____	Other (specify)		
$ _____	Total Assets	$ _____	Total Liabilities

NET WORTH

$ _____ Total assets

(minus) $ _____ Total liabilities

_____

(equals) $ _____ Net worth

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PART III – BUSINESS INSURANCE

DETAILS OF BUSINESS

Name _____

Address _____

Nature of business _____

How long has company been in existence? _____

When did this individual join the company? _____

Type of organization ❑ Corporation ❑ Partnership ❑ Sole Proprietorship

VALUE OF THE BUSINESS

Current business $ _____ book value

$ _____ market value

Proposed insured's % of ownership of business _____%

PROFITS OF BUSINESS (before taxes and bonuses)

$ _____ year-before-last

$ _____ last year

$ _____ this year (estimated)

PURPOSE OF COVERAGE

❑ Key-person ❑ Buy-sell/stock redemption ❑ Business loan ❑ Other (explain fully on back of form)

IF KEY-PERSON, how is the proposed insured important to the business (special skills, knowledge, or abilities)?

IF BUSINESS LOAN, provide the following information:

Name of lender _____

Address _____

Amount of loan $ _____ Date of loan _____

Repayment terms _____

Purpose of the loan _____

Is the lender requiring this insurance? ❑ Yes ❑ No

WHAT OTHER PERSONS are being insured in favor of the business?

Name	Amount	Insurance Company

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*FRCS-125860763*	*State:*	*Arkansas*
Filing Company:	*Industrial Alliance Pacific Insurance and Financial Services Inc.*	*State Tracking Number:*	*40626*
Company Tracking Number:	*4973*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Supplemental Applications filing*		
Project Name/Number:	*IAPINS/66/66*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 10/15/2008

Comments:

Attachments:

AR COC.pdf

AR RDB.pdf

Auth_dist.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Industrial Alliance Pacific Insurance and Financial Services Inc.

Form Title(s): Non-Medical Questionnaire, Application for Child Rider, Reinstatement/Change Application, Supplementary Application, Part II Application, Financial Statement

Form Number(s): FORM 9566-AR, FORM 9587-AR, FORM 9589-AR, FORM 9593-AR, FORM 9605-AR, FORM 9713-AR

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.

Michael L. Stickney
Executive Vice-President, U.S. Development

October 14, 2008
Date

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Industrial Alliance Pacific Insurance and Financial Services Inc.

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
FORM 9566-AR	73
FORM 9587-AR	47
FORM 9589-AR	49
FORM 9593-AR	50
FORM 9605-AR	50
FORM 9713-AR	40

Michael L. Stickney
Executive Vice-President, U.S. Development

October 14, 2008
Date

INDUSTRIAL ALLIANCE *PACIFIC*™
INSURANCE AND FINANCIAL SERVICES™

INDUSTRIAL ALLIANCE PACIFIC INSURANCE AND FINANCIAL SERVICES INC.
P.O. Box 8118, Blaine, WA 98231-8118, Tel: (425) 646-6467
Tel: (425) 646-6467, Fax: (604) 682-2013

May 29, 2008

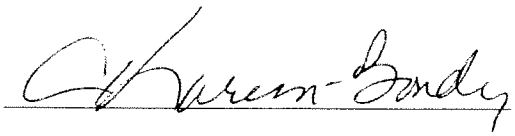
To The Insurance Commissioner

AUTHORIZATION

This letter, or a copy thereof, authorizes the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, and its employees, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Industrial Alliance Pacific Insurance and
Financial Services Inc.

Signature: 

Name: Azmina A. Karim-Bondy

Title: Assistant Corporate Secretary